TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
UNITED REGIONAL MEDICAL CENTER

Respondent Name
CITY OF WICHITA FALLS

MFDR Tracking Number
M4-18-0560-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 30, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "[The injured employee] presented to our emergency department for treatment of a laceration that not only required sutures and local anesthesia, but the wound had to be explored for possible foreign bodies as well. . . . detailed history was documented and treatment rendered as determined by the provider."

Amount in Dispute: $979.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Emergency Room record does not support Moderate complexity medical decision nor was the presenting problem of high severity."

Response Submitted by: Edwards Claims Administration

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 7, 2017	Outpatient Hospital Services	$979.00	$430.28

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - P14 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - P14 – Integral part of ER or surgical procedure and is global of reimbursement for the facility/APC rate.

- 150 – Documentation does not support the requirements for billing for code 99284 emergency department visit are met. Those requirements include: A. Key Components (All 3 requirements): 1. A detailed history, 2. A detailed examination, 3. Moderate complexity medical decision. B. Problem Severity: 1. High severity, 2. Requires urgent evaluation, 3. Does not pose an immediate significant threat to life or physiologic function. Minor repair of finger laceration does not meet criteria for problem severity.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied evaluation and management code 99284 with reason code 150:

   > Documentation does not support the requirements for billing for code 99284 emergency department visit are met. Those requirements include: A. Key Components (All 3 requirements): 1. A detailed history, 2. A detailed examination, 3. Moderate complexity medical decision. B. Problem Severity: 1. High severity, 2. Requires urgent evaluation, 3. Does not pose an immediate significant threat to life or physiologic function. Minor repair of finger laceration does not meet criteria for problem severity.

   The respondent further states in the position statement, "The Emergency Room record does not support Moderate complexity medical decision nor was the presenting problem of high severity."

   E&M code 99284 is defined as

   > Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and patient's needs.

   Review of the submitted medical record finds documentation to support an extended history of present illness, a complete review of symptoms, and a complete review of past medical, family and social history sufficient to support a comprehensive history.

   A physical examination of eight or more systems was documented and found to support a comprehensive exam.

   As for complexity, the problem was new to the examiner, without additional planned workup. The diagnostic data reviewed was minimal, the injury presented as acute without complications, and the management option selected was minor surgery (wound closure of superficial laceration to an extremity). However, the provider documented the presence of an identified risk factor: the possible presence of foreign bodies, which required exploration of the wound to rule out. This is sufficient to elevate the complexity of medical decision-making to "moderate," per Medicare's evaluation & management guidelines.

   Consequently, the division finds the provider has documented the three key components of the definition of the code. The requestor has thus fulfilled the documentation requirements to support the code as billed.

   The insurance carrier's denial reasons are not supported. Accordingly, the disputed services will be reviewed for reimbursement according to applicable division rules and fee guidelines.

2. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying the effective Medicare Outpatient Prospective Payment System (OPPS) formula and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services (CMS) at http://www.cms.gov.

   Rule §134.403(f)(1) requires that the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent.

Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) to billed services based on procedure code and supporting documentation. The APC determines the payment rate. Payment for ancillary items and services is packaged into the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 12002 has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for the emergency visit evaluation and management code 99284 billed on the same claim.
- Procedure code 99284 denotes a hospital, clinic or emergency room visits. This code is assigned APC 5024, which has status indicator V, and the OPPS Addendum A rate is $332.41, which is multiplied by 60% for an unadjusted labor-related amount of $199.45, in turn multiplied by the facility wage index of 0.8896 for an adjusted labor amount of $177.43. The non-labor related portion is 40% of the APC rate, or $132.96. The sum of the labor and non-labor portions is $310.39. This service is not eligible for outlier payment, as the cost of services does not exceed the fixed-dollar threshold of $3,825. The Medicare facility specific amount of $310.39 is multiplied by 200% for a MAR of $620.78.

3. The total recommended reimbursement for the disputed services is $620.78. The insurance carrier has paid $190.50, leaving an amount due to the requestor of $430.28. This amount is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $430.28.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $430.28, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	December 14, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (form DWC045M) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.